MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1149

PLACE OF DEATH

County McDonald

Township White Rock — Registration District No. _____ File No. 9047

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____ _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME William Benton Stewart

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	

DATE OF BIRTH: Nov (Month) 4 (Day), 1844 (Year)

AGE: 8 yrs. 4 mos. 11 ds. — If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): _____

BIRTHPLACE (City or town, State or foreign country): Berry Co Mo

PARENTS

NAME OF FATHER: Josiah Stewart

BIRTHPLACE OF FATHER (City or town, State or foreign country): S C

MAIDEN NAME OF MOTHER: Matilda Payne

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Dont Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T P Stewart

(ADDRESS) Jane Mo

Filed Mch 17, 1926 — O L Johns, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Mch (Month) 17 (Day), 1926 (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191___, to Mch 17, 1926, that I last saw him alive on Mch 17, 1926 and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

a zoolexy

Duration _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) Dont Know

Duration _____ yrs. _____ mos. _____ ds.

(Signed) O L Johns M. D.

(Address) Purdwell

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Jane Mo	Mch 17, 1926
UNDERTAKER	**ADDRESS**
W B Russell	Jane

MISSOURI STATE BOARD OF
BUREAU OF VITAL STATIST
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____
or
Village _____ Primary Registration District No. _____ Registered No. _____
or
City _____ (NO. _____, _____ St.; _____ Ward)

[If dea
hospital
give its
of street

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____, 1_____
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds. | If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____
(Month) (D

I HEREBY CERTIFY, that I attended de
_____, 191____, to _____
that I last saw h____ alive on _____
and that death occurred, on the date stated above, a
The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos

Contributory _____
(SECONDARY)
_____ (Duration) _____ yrs. _____ mos

(Signed) _____

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TR
RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mo

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BU
UNDERTAKER	ADDRESS